الأمسية الاولي ل"أنت تسأل و الأستاذ يجيب"

مع راعي التخصص و ملاكه الحارس **ا.د علياء عمر الهادي**

برعاية رابطة أطباء الطب الطبيعي و الروماتيزم و التأهيل بالشرقية

30 December 2016



Yara Tawfik

30 December 2016 at 18:48

السلام عليكم و رحمة الله و بركاته
اساتذتى الأفاضل ، زملائى الأعزاء
جمعة طيبة مباركة 🌺✿🌺✿🌺✿
اليوم ستقدم رابطة الشرقية ممثلة فى الزميلتين المتألقتين د. مروة صديق ، و د. جيهان الزهيرى ،، أولى اللقاءات العلمية المباشرة ،، عملا بحديث رسول الله-صلى الله عليه و سلم : خيركم من تعلم العلم و علمه ..
و البداية ستكون مع د. علياء عمر الهادى ،، الأم الروحية للتخصص ،، حبيبة الجميع ،، و التى طالما تدعو أن تكون من أنفع الناس للناس و أحسب الله قد استجاب لها بكرمه و فضله و أكرمنا الله بها معلمة و استاذة معطاءة
و سيكون موضوع اللقاء
*** Entrapment Neuropathies***
موضوع مهم و كلنا بنقابله و ان شاء الله نستفيد من فيض علم استاذتنا ...

انتهز الفرصة و اشكر الزميلة العزيزة د. مروة صديق و التى شرفتنى و اختارتنى معها لإدارة الحوار الأول ،، ترسيخا للتعاون بين روابط المحافظات و تأكيدا على أن الهدف الأساسى هو نشر العلم و تكسير كل القيود الزمانية و المكانية 😊☺😊☺

أتركا مع استاذتنا الغالية د. علياء الهادى و نبذة عن الموضوع بأسلوبها المميز 😊
☺😊☺😊☺
Dr. Aliaa Omar El-hady

Marwa Sedik
Yara اهلا وسهلا بك الطبيبة الماهرة والمحاورة المميزة د.يارا توفيق
Tawfik...منورة رابطة الشرقية وياارب دايما وشكرا على قبولك الدعوة ..
منتظرين بفارغ الصبر هذا اللقاء العلمى المميز باذن الله ومنتظرين استاذتنا د.علياء ومشاركة حضراتكم ونسال الله العلى القدير ان يجعل هذا العمل خالصا لوجهة وان يجعلة فى ميزاننا يوم العرض وان ينفع بنا وينفعنا بالعلم ويجعلنا سببا فى شفاء مرضانا...امين يارب العالمين

Sabrien Hamza
عمل موفق باذن الله... وبداية رائعة لعاالم افضل باذن الله

Aliaa Omar El-hady
Aliaa Omar El-hady
بسم الله الرحمن الرحيم وبه نستعين... اسأل الله العظيم ان ينفعنا بما علمنا ويعلمنا ما جهلنا ويزدنا علما .... جزيل الشكر لرابطة اطباء الشرقية على استضافتى للحديث معهم وعلى رأسهم د. مروة صديق واشكر د. يارا توفيق المحاورة الجميلة على ادارة الحوار

Marwa Sedik

اهلا وسهلا باستاذتنا الفاضلة د.علياء..منورة رابطة الشرقية لاول مرة وخير استهلال لفقرتنا الاسبوعية ..جزاكم الله خيرا وربنا يعجلة فى ميزانك..كلنا اذان صاغية لحضرتك ونرجو ان يتسع صدرك ووقتك لأسئلتنا يافندم ..على بركة الله..نبدا😘😮😘😮😍🙂😍🙂

Aliaa Omar El-hady

اهلا بك حبيبتى وبرابطة اطباء الشرقية كلها ... سعدت بوجودى معكم واتشرف بكم

Aliaa Omar El-hady

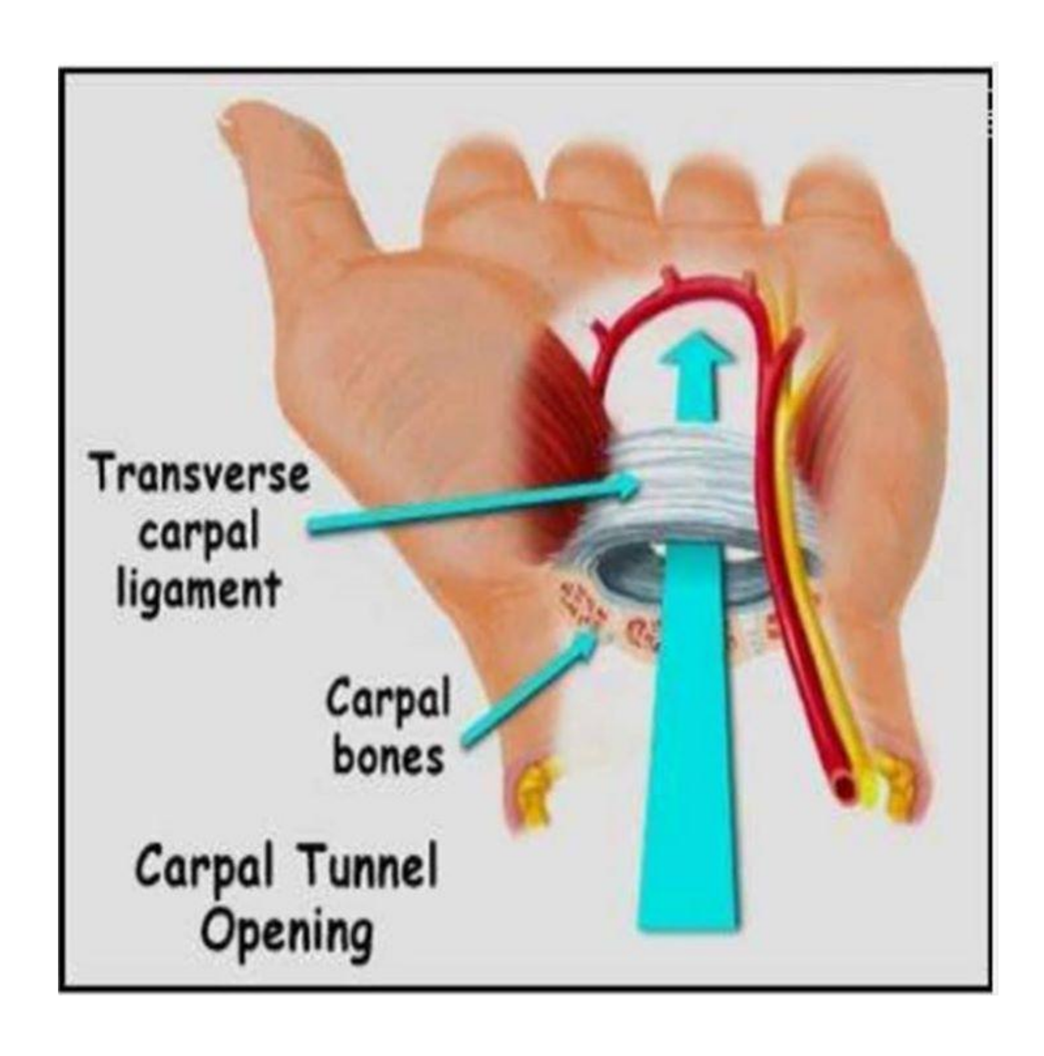
30 December 2016 at 19:04

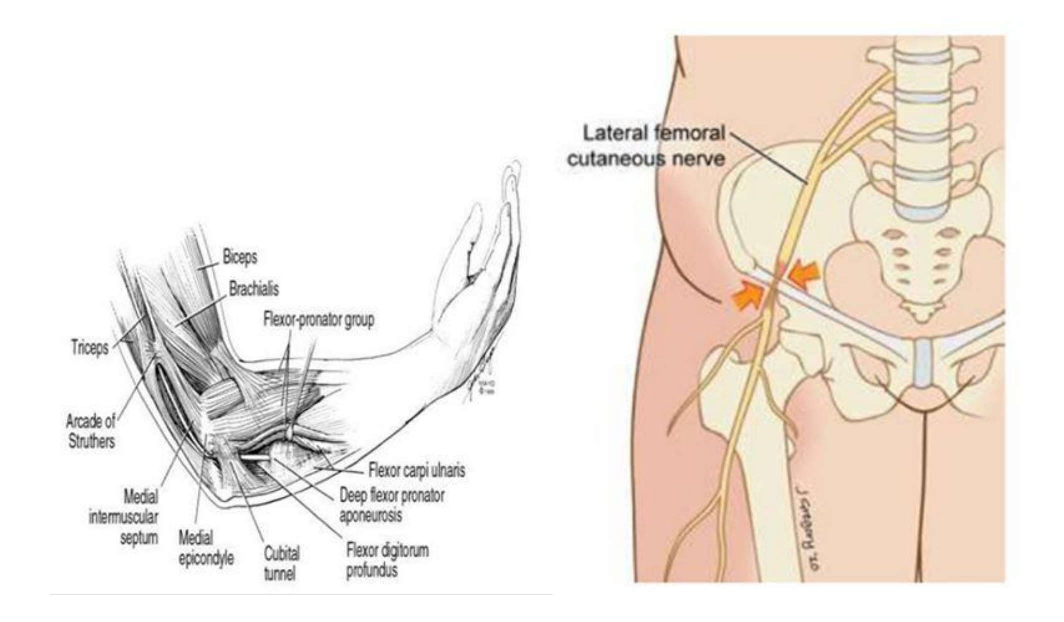
بسم الله الرحمن الرحيم وبه نستعين... اسأل الله العظيم ان ينفعنا بما علمنا ويعلمنا ما جهلنا ويزدنا علما .... جزيل الشكر لرابطة اطباء الشرقية على استضافتى للحديث معهم وعلى رأسهم د. مروة صديق واشكر د. يارا توفيق المحاورة الجميلة على ادارة الحوار
واستأذنكم لضيق الكومنتات انى احط ملخص للموضوع الجميل ده فى ٤٤ بوستات مرقمة تغطى الموضوع كله ... واعذرونى انى ما لحقتش اجيب صور لها ولكن اوعدكم انى احط الموضوع كامل بعد كدة على جروب ال basic كله بالصور الموضحة



Entrapment Neuropathy(1)
=======================
DEFINITION:
===========
Entrapment neuropathy is defined as “Pressure or pressure induced injury to a segment of a peripheral nerve secondary to anatomical or pathologic structures”
يعنى العصب وهو ماشى فى طريقه اتزنق او انضغط سواء بحاجة فى الجسم نفسه
او من الخارج عورته والضغط عليه اتسبب فى انه اثر على جزء منه
TYPES:
=======
UPPER LIMB
==========
• Carpal tunnel syndrome
• Cubital tunnel syndrome
• Supraspinatus syndrome
• Anterior interosseous syndrome
• Posterior interosseous syndrome
LOWER LIMB
==========
• Meralgia paresthetica
• Tarsal tunnel syndrome
• Piriformis syndrome
• Peroneal tunnel syndrome
Controversial entrapment neuropathies like
=================================
• Radial tunnel syndrome
• Tarsal tunnel syndrome
• Piriformis syndromes.
ANATOMY
========
In general all entrapments have any one of the following basic structure –
1.Fibro-osseous tunnels like
• Carpal tunnel(median nerve)
• Tarsal tunnel(posterior tibial nerve)
• Suprascapular tunnel (suprascapular nerve)

2.Fibrotendinous arcade at theorigin of certain muscle-
• Supinator(arcade of Frohse)
• Flexor carpi ulnaris (cubital tunnel)
• Flexor digitorum sublimis (sublimis bridge)
• Common peroneal nerve entrapment
• Anterior and posterior interosseous nerve entrapments
• Piriformis syndrome
3.Abnormal bands causing compression-
• Thoracic outlet syndrome
• Meralgia paresthetica




Biceps
Brachialis
Flexor-pronator group
Triceps
Arcade of Struthers
Flexor carpi ulnaris
Medial intermuscular septum
Deep flexor pronator aponeurosis
Medial epicondyle
Cubital tunnel
Flexor digitorum profundus
Lateral femoral cutaneous nerve

Entrapment Neuropathy(2)
======================
CARPAL TUNNEL
==============
Anatomy
======
- Fibro-osseous passageway in the anterior aspect of the wrist formed by the carpal bones and flexor retinaculum
- Floor volar radiocarpal ligament
- Roof Transverse Carpal Ligament(TCL), attaches medially to the pisiform and hook of the hamate and laterally to the scaphoid tuberosity and crest of the trapezium.
- The TCL is approximately 3 to 4 cm in width and 2.5 to 3.5 mm in thickness and is 4 to 6 cm in length

Contents
=========
1.The median nerve and its vascular bundle,
2.Tendons- flexor digitorum superficialis(FDS), profundus (FDP) and flexor pollicis longus

ULNAR NERVE ENTRAPMENT
=========================
- Most common site of entrapment between the medial epicondyle and olecranon within the cubital tunnel
- Roof cubital tunnel retinaculum or arcuate ligament of Osborne which extends from tip of the olecranon to the medial epicondyle.
- Fibers oriented in transverse fashion and become taut with elbow flexion.
- Floor capsule of the elbow joint and medial collateral ligament.
- Walls medial epicondyle and olecranon.

POSTERIOR INTEROSSEOUS NERVE ENTRAPMENT
==
- Terminal branch of radial nerve arising in front of the

lateral epicondyle of elbow
• Supplies extensor carpi radialis brevis and supinator and enters arcade of Frohse which is the usual site of entrapment.
• Arcade is a tough fibrotendinous ring like structure at the origin of supinator muscle.
• Arcade is absent in full term fetuses and seen in 30% adults indicating that “the arcade is probably formed in the most proximal part of the superficial head of the supinator in response to repeated rotary movement of the forearm”
• It passes in the dorsal aspect of forearm and supplies most of the extensors of hand and wrist.• No cutaneous branches

ANTERIOR INTEROSSEUS SYNDROME
====================================

• principally a motor nerve
• branch of median nerve in proximal forearm arising variably between the 2 heads of pronator teres, descends vertically in front of interosseous membrane between flexor digitorum profundus and flexor pollicis longus, supplies these 2 muscles and terminates by supplying the pronator quadratus.
• The nerve can get entrapped due to fractures, penetrating wounds, constricting bands mostly near its origin
.• In majority the cause is not found

ANATOMY RADIAL TUNNEL SYNDROME
====================================

• Radial tunnel is the space surrounding the distal radial nerve and proximal PIN from humero-radial joint to within the supinator muscle.
The tunnel is 5 cm long, is anterior to proximal radius.
The floor is formed by capsule ofradial capitulum.
The brachioradialis,ECRL and ECRB form lateral wall and biceps and brachialis form the medialwall.

SUPRASCAPULAR ENTRAPMENT
============================
• Suprascapular nerve is a mixed nerve arising from superior trunk of brachial plexus.
• Supplies supraspinatus, infraspinatus and sensory supply to capsule of shoulder joint.
• Runs through posterior triangle of neck, parallel to inferior belly of digastric under trapezius, through suprascapular notch, below suprascapular ligament and into suspinous fossa. From there loops around the lateral angle of spine and enters deep surface of infraspinatus to supply it.
• The nerve commonly gets trapped in the suprascapular notch, rarely in spinoglenoid notch
THORACIC OUTLET SYNDROME
============================
• The thoracic outlet refers to the communication of the thoracic cavity with the root of the neck.
• There are three sites within the thoracic outlet where neurovascular compression may occur:
• The interscalene triangle
• The costoclavicular space
• The subpectoral tunnel.
The most important passageway clinically is interscalene triangle,bordered by anterior scalene muscle anteriorly, middle scalene muscleposteriorly and medial surface of the first rib inferiorly.Contains trunks of the brachial plexus and subclavian artery
TARSAL TUNNEL SYNDROME
==========================
• The TT is a continuation of the deep posterior compartment of the calf into the posteromedial aspect of the ankle and the medial plantar aspect of the foot
.• The TT is made up of two main compartments
:• An upper (tibiotalar) and a lower (talocalcaneal)

compartment
.• Floor of the upper compartment posterior aspect of the tibia and the talus
• The posterior tibial neurovascular bundle runs through this space with the tendons of the Tibialis Posterior, Flexor Digitorum Longus and Flexor Hallucis Longus.
The lower compartment of the TT contains the abductor hallucis muscle.
• The tibial nerve passes within the upper compartment of the TT posterior to the tendons of the TP and FDL and the posterior tibial artery and vein.
• The medial and inferior calcaneal nerves may arise proximal to, within or distal to the TT. 1. TIBIALIS POSTERIOR TENDON• The roof is formed by a 2. FDL TENDON 3. TIBIAL NERVE deep aponeurosis. 4. FLEXOR RETINACULUM 5. MEDIAL PLANTAR NERVE 6. LATERAL PLANTAR NERVE
PIRIFORMIS SYNDROME
=====================
• Piriformis originates from the anterior surface of the sacrum and the superior margin of the greater sciatic notch. It also has attachment to the capsule of the sacro-iliacjoint and also the sacrotuberous ligament.
• Exits pelvis through greater sciatic notch, fibres inserted into the superior aspect of the greater trochanter of the femur
• The sciatic nerve passes deep to piriformis in most cases (approximately 85% of people) but can pierce the piriformis itself, predisposing to piriformis syndrome and subsequent sciatica.
• Even if the sciatic nerve runs deep to piriformis, spasm in this muscle put direct pressure on the nerve, causing the resultant pain and discomfort.
COMMON PERONEAL NERVE ENTRAPMENT
=====================================

• The common peroneal nerve after emerging out of the popliteal fossa courses around the fibular neck and passes through the fibro-osseous opening in the superficial head of the peroneus longus muscle at its origin which forms a sharp crescentric arch
• This opening can be quite tough, and can result in the nerve angulating through it at an acute angle• Fibrous connective tissue secures the nerve to this proximal portion of the fibula, potentially compromising the nerve
• This opening in peroneus longus is called fibular tunnel where the common peroneal nerve gets entrapped commonly

Entrapment Neuropathy(3)
======================
PATHOLOGY
==========
• The effect of nerve compression is mediated by ischemia and edema.
1. Disruption of blood nerve barrier
2.Dysfunction of intraneural circulation reversible
3.Segmental demyelination
4.Edema
1.Epineural fibrosis irreversible
2.Thickening of nerve
3.Myelin sheath damage
4.Axonal disruption
PREDISPOSING FACTORS
=======================
Congenital narrowing of osseous canal through which the nerve traverses like increased carrying angle malunited epiphysis
Thickening of overlying retinaculum due to systemic diseases like hypothyroidism,occupation related like carpenters and musician shaving thickened flexor retinaculum in the wrist
CAUSES
========
1.Normal anatomy with abnormal contents

• Tumors- intraneural neuroma, lipoma, Ganglion, schwannoma, hemangioma, neurofibroma, desmoid tumors, angiomas, fibrolipomatosis, hamartomas, vascular abnormalities.
Exostosis, chondromatosis,
• Congenital- Persistent median artery as in carpal tunnel
• Rudimentary cervical rib in TOS
• Anamolous fibrous bands

2.Abnormal anatomy of the normal contents

• Inflammation or edema of surrounding structures
• Accessory or hypertrophic muscles
• Tenosynovitis
• Prominent C7 transverse process in TOS
• Reflex spasm of the muscle like piriformis in piriformis syndrome
• Abnormal course of the nerve through the muscle or its tendon –sciatic nerve through the piriformis
• Altered biomechanics resulting from limb length discrepancy leading to stretching and shortening of the muscle like piriformis
• Malunited fractures like fibular neck
Common Conditions Associated with Carpal Tunnel Syndrome
==
====
Metabolic/endocrine:
Anatomic:
• Diabetes mellitus
• Persistent median artery
• Pregnancy
• Anomalous tendons or muscles
• Hypothyroidism
• Congenital stenosis of the carpal tunnel
• Acromegaly
• Fracture and/or dislocation at the wrist
• Renal failure Infectious:
• Pyridoxine (vitamin B6) deficiency
• Septic arthritis
Autoimmune/inflammatory:
• Lyme disease
• Rheumatoid arthritis
• Tuberculosis

• Amyloidosis
• Histoplasmosis
• Sarcoidosis
Neoplasm:
• Tenosynovitis
• Nerve sheath tumor
• Ganglion cyst

CLINICAL PRESENTATION
=======================

Age and gender vary-

• Carpal tunnel- Middle aged female
• Thoracic outlet syndrome- young, thin female with a long neck and drooping shoulders
• Meralgia Paresthetica- middle aged over-weight men
• Athletes in general predisposed to cubital tunnel syndrome, thoracic outlet syndrome, piriformis syndrome

Occupation :
----

carpentry, painting, and musicians are moresusceptible for Ulnar nerve compression
Military personal wearing heavy belts -meralgia paresthetica
Postural variation -Symptom aggravated by standing and walkingand relieved by rest in meralgia paresthetica

COMPLAINTS

• Pain, numbness are the early symptoms
.• weakness, wasting, deformity are the late symptoms.
Certain syndromes have specific symptoms like
• nocturnal increase in pain with disturbed sleep
- Carpal tunnel syndrome and Tarsal tunnel syndrome
• Vasomotor disturbances such as changes in skin color and temperature - thoracic outlet syndrome
• Motor weakness may precede sensory disturbances

because of the predominance of motor fibers within the Ulnar nerve as in Cubital tunnel

• Frequent dropping of objects - Ulnar nerve involvement

SIGNS
======

• Sensory loss in the distribution of the nerve
• Wasting of the muscles supplied by the nerve
• Deformities of the hand/leg due to selective involvement of the muscles like clawed hand in ulnar involvement, foot drop in common peroneal involvement
• Trophic ulcers in the distribution of the nerve in long standing sensory nerve involvement
• Flick sign- To relieve the symptoms, patients often “flick” their wrist as if shaking down a thermometer in Carpal tunnel syndrome

TINELS SIGN: Tapping of the nerve at the site of involvementproduces paresthesia all along the distribution ofthe nerve

PHALENS MANEUVER: It reproduces the symptoms in Carpal tunnel syndrome

ROOS TEST: Elevated arm stress test to induce reproduction of the neurological symptoms in Thoracic Outlet Syndrome

WRIGHT TEST: Progressive shoulder abduction to reproduce the symptoms in Thoracic Outlet Syndrome

ADSON TEST: Full neck extension and head rotation toward the side being examined, during deep inhalation, to detect a reduction in radial pulse amplitude in thoracic outlet syndrome

WARTENBERG SIGN: In ulnar nerve compression the third volar interosseous muscle is weak and allows the extensor digiti minimi to abduct the fifth finger during extension causing finger catching while placing the affected hand in pocket.

Entrapment Neuropathy(4)
======================
Differential Diagnosis of Cubital Tunnel Syndrome
=======================================
• Spinal cord Cervical spondylotic myelopathy Cervical syrinx Cervical spinal cord tumor
• Nerve root Motor neuron disease(Amyotrophic lateral sclerosis (ALS)-initial stages) C8 or T1 radiculopathy
• Peripheral nerve Brachial plexopathy (lower trunk or medial cord)
• Ulnar nerve Nerve sheath tumor Ulnar nerve compression at the arcade of Struthers.
Ulnar nerve entrapment at Guyons canal
===============================
• Other Peripheral neuropathy Thoracic outlet syndrome Differential Diagnoses for Neurogenic Thoracic Outlet syndrome
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====
Spinal Cervical disk disease or foraminal stenosis
Cervical spinal cord tumor
Cervical syrinx
Peripheral nerve
Brachial plexitis
Median nerve entrapment neuropathy
Ulnar nerve entrapment neuropathy
Nerve sheath tumor
Orthopedic :Shoulder abnormalities (rotator cuff injury)
Other Complex regional pain syndrome
Fibromyalgia
Apical lung lesion (Pancoasts tumor)
INVESTIGATIONS
================
X-rays - To see for any fractures, osteophyte formation,hypertrophic changes, cervical rib

Ultrasound - to see for abnormal contents like tumors, cysts,varicosities, edema of the surrounding structures.
• Refinements of the techniques has allowed direct visualization of neural structures and associated sites of constriction or compression.
• Entrapped peripheral nerves appear swollen, hypo echoic or flattened.
• Is found useful and highly sensitive is CTS, UN entrapment, suprascapular, axillary and radial neuropathies

ELECTROPHYSIOLOGY
===================

• Electrophysiology is an important investigation
• EMG and NCSs use different means of measuring action potentials of nerve axons or muscle fibers
• SNAP(Sensory nerve action potentials) and CMAP(Compound Muscle Action Potential) are recorded on both the limbs for comparison and in different nerves of same limb to rule out symmetric involvement.
• These recordings should be done across the suspected area of the lesion
• Recording should be done by inching technique.
• In entrapments generally the latency is increased, conduction velocity is reduced and amplitude is reduced in later stages.

MAGNETIC RESONANCE IMAGING
==============================

• Greater sensitivity in the detection of peripheral nerve inflammation
.

TREATMENT
=========

NON-SURGICAL
==============

GENERAL

• Splints, physical therapy, ultrasound therapy, ice and heat therapy, diuretics, nonsteroidal anti-inflammatory drugs (NSAIDs)
• Corticosteroids (either oral or direct)
• Avoid positions that trigger pain
• Lifestyle modification: avoidance of activities that exacerbate or provoke symptoms
• Correcting poor posture
• Nerve blocks
• Muscle denervation through targeted injection of botulinum toxin
• Psychological counseling

SPECIFIC
=======

• Resting the affected shoulder as in suprascapular entrapment
• Weight reduction in obese people in meralgia paresthetica
• Physiotherapy-example, Piriformis stretching exercises
• Sports massage techniques

WRIST SPLINTS
LOCAL STEROID INJECTION
PERINEURAL INJECTION
PRP
PROLOTHERAPY
MESOTHERAPY
HYDRODISSECTION
SURGICAL TREATMENT

Yara Tawfik
30 December 2016 at 21:00

كل الشكر و الامتنان لأستاذتنا د علياء
Omar El-hady Aliaa .Dr

على هذا الحوار المميز ،، و الرد على اسئلة زملاءنا 👏🖐👏🖐👏🖐👏🖐👏🖐
👏🖐 ...
جزاها الله عنا خيرا 🌸✿🌸✿🌸✿
و فى انتظار تعليقات حضراتكم و اى استفسار او توضيح ،، سواء بكتابة السؤال فى بوست على جروب رابطة الشرقية ،، أو ارساله انبوكس للد. مروة صديق أو لى
طابت ليلتكم 🌹🥀🌹✿🌼🥀

Aliaa Omar El-hady
30 December 2016 at 19:13

وبكدة يبقى تناولنا كل ابعاد الموضوع بتاع ال entrapment neuropathy
اتكلمنا عن
defenition
(،signs & diseases (anatomy, pathology, symptoms
differential diagnosis
investigation
treatment
دلوقتى نفتح للاسئلة بعد ما تبصوا على الاربع بوستات



Marwa Sedik
ربنا يعزك د.علياء... التلخيص مرتب ومنظم جدااا .. انا كمان بقراة ومستمتعة وبستزيد من معلومات حضرتك وسابدا مع حضرتك النقاش ان شاء الله
Aliaa Omar El-hady
اتفضلى ... اهلا وسهلا
Marwa Sedik
شكرا يافندم...سؤالى لحضرتك...كثير منا عاوز يفهم بشكل مبسط وباسلوب حضرتك المميز انا كنايب فى العيادة وجاتلى حالة entrapment
How to differentiate clinically between peripheral nerve entrapement and radiculopathy.... more by clinical than NCS...
thank you Dr. Aliaa Omar El-hady
Aliaa Omar El-hady
اولا المريض بييجى يشتكى حسب العضو اللى بيوجعه سواء ايده والا رجله والا كوعه ... بيشتكى بألم ومعاه تنميل او حرقان ... او لو كانت مزمنة بيشتكى من ضعف بالعضلات او انها خست او انها متيبسة مش قادر يحركها او تعمل شغل البيت وممكن تلاقى فيها trophic changes طيب اعرف منين انى افرق ان neuropathy or plexopathy or radiculopathy لازم اكون عارف كويس الاناتومى زى اسمى وكمان اعرف اعمل complete neurological examination ويعنى ايه dermatome اعرف يعنى ايه myotome مثلا لو العيان بيشتكى من الم وتنميل فى صباعه الصغير يبقى لازم افرق ان الالم والتنميل ده سببه ulnar nerve او C8T1 plexopathy or radiculopathy
Aliaa Omar El-hady
لو عملت examination motor, sensory, reflexes ولقيت ان الجزء المصاب فقط فى ال ulnar nerve يبقى ulnar mononeuropathy ولو لقيته extend to other nerves supplied by same roots C8T1 as TOS يبقى plexus or root ونفصل بينهم ب ال EMG

Marwa Sedik
تمام يافندم ويطبق هذا لو عاوزين نفرق مثلا CTS و Cervical radiculopathy وهكذا...

Aliaa Omar El-hady
طبعا ... CTS بافرقه عن اللى طالع معاه من نفس ال roots يعنى لازم اعمل فحص ل C5,6,7 اشوف ال deltoid supplied by axillary واشوف ال biceps & ‹supraspinatus supplied by suprascapular supplied by musculocutaneous

Marwa Sedik
السؤال التانى ..ياريت حضرتك توضحى باسلوب مبسط والمبتدئين امثالى فى مجالNCS...
NCS of TOS as a type of entrapment
وخصوصا لو محتاجين نفسر التقرير

Aliaa Omar El-hady TOS is a neurovascular synd. , affects C8T1 roots, we must do motor NCS to median nerve recorded from abductor pollicis brevis (C8,T1), and motor NCS to ulnar nerve recorded from abductor digiti minimi (C8,T1), sensory NCS to median nerve from index (C6), sensory NCS to ulnar nerve (C8T1), and medial antebrachial nerve (sensory C7), F-response from median & ulnar ... If C7,8T1 affected without sensory median (C6) we suspect , must do EMG to confirm ... but if you suspect send to do x-ray to exclude cervical rib and MSUS to confirm the diagnosis

Marwa Sedik
السؤال الثالث... in demylination disease in peripheral
how to diff .. entrapment neuropathy neuropathy and between them in NCS

Aliaa Omar El-hady In demyelinating neuropathy , in conduction studies the distal latency show delay more than 30% of normal, conduction velocity show delay more than 25% of normal, with or without reduce amplitude, we have to stimulate above and below the neuropathic patch , if reduce amplitude across the lesion then we have a conduction block

Aliaa Omar El-hady In peripheral neuropathy many nerves show demyelination (delay in conduction and latency) not just one nerve
Aliaa Omar El-hady In upper & lower limbs
Marwa Sedik
السؤال الرابع. والاخير بالنسبة لى ...وستكمل معكى د.يارا ان شاء الله
Marwa Sedik
متقلقيش د.علياء..عارفة ان وقت حضرتك ضيق....مش حنطول عليكى
Aliaa Omar El-hady
Marwa Sedik in most of report Of NCS of any entrapment we always see what is called (F.wave)..please simplify this point ..what about f.wave ??
Aliaa Omar El-hady
F wave is a motor late respose ودى بتدل على ايه؟؟ بتدل على انى لما القط مثلا من APB muscle & stimulate median nerve ولكن فى الحالة دى انا عايزة اعمل حاجتين فى نفس الوقت ... انا عايزة افحص ال M response of motor median nerve وكمان افحص ال root بتاعها اللى هو C8T1 اقوم اقلب ال stimulator تقوم ال stimulus تمشى من ال stimulating site at wrist وتمشى الى ال spine وتوصل الى ال anterior horn cell وتلف وترجع تانى الى stimulation site . then we record M respose first then late f response ...any lesion in its course from stimulating site to AHC then to the site again cause delay in f-response ...then it is not just indicate radiculopathy but also it delays in neuropathy
Yara Tawfik
د.علياء ،، استاذتنا الفاضلة ،، هستلم الميكرفون من الزميلة العزيزة د. مروة 😃😊
😊😃
فى سؤال لحضرتك
For how long should I continue in medical & physical ttt of entrapment neuropathies , without fear of bad progress of the case؟؟
When to shift urgently to surgery؟؟؟

Aliaa Omar El-hady
لو المريض بيشتكى وشكوته مؤثرة على عمله .. مش قادرة تخدم اولادها ... مش قادر يشتغل شغله اليدوى ..نجار خباز مدرسة سواق طبيب... وعملت رسم العصب ولقيته moderate entrapment واخد sensory & motor ... واديته

علاج دوائى وطبيعى ومش مستجيب شهر اتنين ثلاثة ولبسته ساند وحقنته ومش متحسن يبقى علاجه جراحى ... لو المريض استنى مثلا على carpal tunnel ورفض العمليه ممكن يحصل ضمور للعضلة الواصلة بالعصب وحتى لو عمل العملية بعد كدة يبقى انتهت مش حيتحسن ودلوقتى فيه جراحات ميكروسكوبية وبالمنظار وبالتخريم ... وعلى فكرة ال perineural بيجيب نتائج رائعة جربته فى كذا حالة النتائج مبهرة

Samarino Helal

بالنسبة للتمارين اللي ممكن تتعمل في حالات اختناق العصب
ليها بروتوكول معين ؟
امتي نبدأ ؟
وامتي نوقفها ؟
في اي مرحلة؟
وبعد الجراحة
د Aliaa Omar El-hady اية افضل سورس ارجعلة بهذا الصدد
وشكرا جزيلا

Aliaa Omar El-hady

30 December 2016 at 21:08

فى نهاية اللقاء العلمى الممتع الجميل ده لا يسعنى الا ان اتقدم بخالص الشكر الى رابطة اطباء الشرقية وعلى رأسهم د. مروة صديق Marwa Sedik وايضا المحاورة الجميلة د. يارا توفيق Yara Tawfik .... ويارب ما اكونش ضيفة تقيلة عليكم ... ويارب دايما نتجمع فى المحافل واللقاءات العلمية الجميلة دى.... سعدت بصحبتكم واسئلتكم وتمتعت بها ... ويارب اكون اجبتكم برد وافى ... اللهم تقبل علمنا وانفع بنا .... جزاكم الله خيرا

